ERRATA

1. Added error codes 100_Mandatory Element Missing and 300_Mandatory Segment to the 997 Functional Acknowledgement Error Codes (page 38).

2. Dropped error codes 125_ Element Delimiter, 210_ Incorrect Component Format, 215_ Incorrect Component Length, 220_ Component Delimiter, 310_ Invalid Start End, 320_ Segment Terminator, 410_ Invalid Control Number, and 430_ Unknown Version from the 997 Functional Acknowledgement Error Codes (page 38).

3. The DWC\WCIS has developed a several Medical Bill Payment scenarios for California including Medical Provider Networks and reevaluations to be included in the batch of test files. (page 36)

4. The DWC\WCIS Medical Bill Payment Medical Provider Networks and reevaluations as well as other specific scenarios will be tested for validity and accuracy. (page 42)

5. Segment BGN to BHT on page 50.

6. Segment MN1 to NM1 on pages 50, 52, and 54.

7. Segment TP to DTP on page 51.

8. “BR” to “E or R” p39.

9. “BA” to “A” p39.

10. Loop 2010C to loop 2000C on p39.

11. “If DN 502, value is "RX" or “MO” DN571 DRUGS/SUPPLIES NUMBER OF DAYS, page 77.

12. “If DN 502, value is "RX" or “MO” DN570 DRUGS/SUPPLIES QUANTITY DISPENSED, page 77.

13. “If DN 502, value is "RX" or “MO” DN572 DRUGS/SUPPLIES BILLED AMOUNT, page 77.

14. Changed from “M” to “C” with a mandatory trigger.

557	Diagnosis Pointer	~~M~~ C	O	O	If DN503 equals “B” and DN714 or DN715 is present
714	HCPCS Line Procedure Billed Code	~~M~~ C	O	O	If different then DN715
522	ICD_9 CM Diagnosis code	~~M~~ C	O	O	If DN502 not equal MO or RX
715	Jurisdictional procedure billed code	~~M~~ C	O	O	If procedure is included in the California OMFS
729	Jurisdictional procedure paid code	~~M~~ C	O	O	If different than DN715
524	Procedure Date	~~M~~ C	O	O	If DN 503 equals “A” and a surgical procedure was preforme
552	Total charge per line other	~~M~~ C	O	O	If DN502 not equal MO or RX
542	BILLING PROVIDER POSTAL CODE	C	O	O	If different than DN656
630	BILLING PROVIDER STATE LICENSE NUMBER	C	O	O	If different than DN643(see WCIS regulations)

15. Change the wording on DN737 HCPCS Bill Procedure code “if DN626 Principle diagnosis is present” to “and more than one procedure preformed”

16. Added Loop 2000B, segment HL on page 50. (IAIABC requirement)

17. Added Loop 2010BA, segment MN1 on page 50. (IAIABC requirement)

18. Remove all FEIN edits (629, 187, 679, 6, 704, 642, 586,) pp. 87-88.

19. Remove error code 040 from DN42 Employee social Security Number on page 84.

20. Removed all name edits (528, 188, 563, 44, 43, 45, 678, 7, 209, 638, and 589) on page 89.

21. Added two data elements, DN525 ICD-9 CM Principle Procedure Code and DN736 ICD_9 CM Procedure Code to tables on pages 51, 72, 80, 84.

22. Changed Health Care Financing Administration (HCFA) to Centers for Medicare & Medicaid Services (CMS), page 99. In response to CWCI comment about references.

23. Deleted reference to Health Care Financing Administration (HCFA), page 100. In response to CWCI comment about references.

24. Deleted Blue Cross and Washington publishing Company on page 116. . In response to CWCI comment about references.

25. Changed DN729 from mandatory to conditional with trigger “ If different then DN715” . In response to PMSI comments about requirements.

26. Deleted error code 056, 062 and 118 page 42 detailed error messages.

27. Rewrote section I pages 56-59. In response to comment from Intracorp.

28. Rewrote section N, pages 89-94. In response to comment from Intracorp requesting clarification.

29. Rewrote section G, pages 34-45. In response to CWCI comment regarding BETA testing.

30. Changed the wording of the mandatory trigger in response to oral comment from Ingenix, ROES and other trading partners during the public comment period. The comments are related to the corrections to data requirements contained in the IAIABC 837 electronic transmission.

718	JURISDICTIONAL MODIFIER BILLED CODE	C	O	O	If DN715 is modified
518	DRG CODE	C	O	O	If DN 503 equals "A" and if included in the California Inpatient Hospital Fee Schedule
550	PRINCIPAL PROCEDURE DATE	C	O	O	If DN 503 equals "A" and if DN525 or DN626 is present
535	ADMITTING DIAGNOSIS CODE	C	O	O	If Billing Format Code, DN 503, is "A" and patient has been admitted
576	REVENUE PAID CODE	C	O	O	If different than DN559
570	DRUGS/SUPPLIES QUANTITY DISPENSED	C	O	O	If DN 502, value is "RX" or “MO”.
571	DRUGS/SUPPLIES NUMBER OF DAYS	C	O	O	If DN 502, value is "RX" or “MO”.
572	DRUGS/SUPPLIES BILLED AMOUNT	C	O	O	If DN 502, value is "RX" or “MO”.

579	DRUGS/SUPPLIES DISPENSING FEE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
562	DISPENSE AS WRITTEN CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
564	BASIS OF COST DETERMINATION CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
721	NDC BILLED CODE	C	O	O	If a pharmaceutical bill or a drug is dispensed by a physician during an office visit.
527	PRESCRIPTION BILL DATE	C	O	O	If different than DN604
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER	C	O	O	If different then DN643
592	RENDERING LINE PROVIDER NATIONAL ID	C	O	O	When available (see WCIS regulations)
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	C	O	O	If different from DN 643
509	SERVICE BILL DATE(S) RANGE	C	O	O	If different than DN605
516	TOTAL AMOUNT PAID PER BILL	C	O	O	If different than DN501
522	ICD-9 CM DIAGNOSIS CODE	C	O	O	If DN521 is present and more then one diagnosis occurs or if DN503 = B and DN714 or DN715 or a drug is dispensed by a physician during an office visit.
567	DME BILLING FREQUENCY CODE	C	O	O	If DN502 = DM and DN565 is present
565	TOTAL CHARGE PER LINE – RENTAL	C	O	O	If Durable Medical Equipment is rented
566	TOTAL CHARGE PER LINE – PURCHASE	C	O	O	If Durable Medical Equipment is purchased
554	DAYS/UNITS BILLED	C	O	O	If DN715 or DN714 are present or DN502 = DM, or a drug is dispensed by a physician during an office visit.
553	DAYS/UNITS CODE	C	O	O	If DN715 or DN714 are present or DN502 = DM or a drug is dispensed by a physician during an office visit.
605	SERVICE LINE DATE(S) RANGE	C	O	O	If not a pharmacy bill submitted on universal claim form/NCPDP format
525	ICD-9 CM PRINCIPAL PROCEDURE CODE	C	O	O	If Billing Format Code, DN 503, is "A" and the code value is not a HCPCS code. For surgical bills only.
736	ICD_9 CM PROCEDURE CODE				If DN525 is present and more than one procedure is preformed
737	HCPCS BILL PROCEDURE CODE	C	O	O	If DN626 is present and more than one procedure is preformed

31. Added a paragraph page 25. . In response to comment from Intracorp requesting clarification.

32. Added a reference to California Department of Consumer Affairs, page 116 in response numerous comments regarding the availability of state license numbers. (CWCI, Intracorp, PMSI).